
Rules of
Department of Social Services
Division 70—Division of Medical Services
Chapter 93—Medicaid Clinic Programs

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**Title 13—DEPARTMENT OF
SOCIAL SERVICES**

**Division 70—Division of Medical
Services**

Chapter 93—Medicaid Clinic Programs

**13 CSR 70-93.010 Reimbursement for
Medicaid Children's Clinic Services**

PURPOSE: This rule establishes the regulatory basis for Title XIX Medicaid payment for children's clinic services.

Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by law.

(1) Authority. This rule is established pursuant to the authorization granted to the Department of Social Services, Division of Medical Services to promulgate rules.

(2) Qualifications. For a clinic to qualify for participation in the Medicaid Children's Clinic (CC) program, the clinic must meet all three (3) of the following criteria:

(A) Have a documented relationship with a department of pediatrics within an accredited school of medicine;

(B) Have a documented relationship with a hospital, exclusively operated for the care and treatment of children; and

(C) Must be open from 3:00 p.m. to 11:00 p.m. or 4:00 p.m. to 12:00 midnight (at least eight (8) hours duration) five days per week, with weekend hours of at least eight (8) hours per day.

(3) General Principles.

(A) The Missouri Medical Assistance (Medicaid) program shall reimburse CC providers based on the reasonable cost of CC-covered services related to the care of Medicaid recipients (within program limitations) less any copayment or other third party liability amounts which may be due from Medicaid recipients effective for services after February 1, 1993.

(B) Reasonable costs shall be determined by the Division of Medical Services based on desk review of the applicable cost reports and shall be subject to adjustment based on field audit. Reasonable costs shall not exceed the

Medicare cost principles set forth in 42 CFR part 413.

(C) Reasonable costs shall be apportioned to the Medicaid program based on a ratio of covered charges for beneficiaries to total charges. Charges mean the regular rate for various services which are established uniformly for Medicaid recipients and other patients.

(4) Definitions.

(A) Desk review. The Division of Medical Services' review of a provider's cost report without on-site audit.

(B) Division. Unless otherwise designated, division refers to the Division of Medical Services, the division of the Department of Social Services charged with administration of Missouri's Medical Assistance (Medicaid) program.

(C) Effective date.

1. The Emergency Rule effective date shall be February 2, 1993.

(D) Facility fiscal year. A facility's twelve (12)-month fiscal reporting period.

(E) Generally accepted accounting principles (GAAP). Accounting conventions, rules and procedures necessary to describe accepted accounting practice at a particular time promulgated by the authoritative body establishing those principles.

(F) Provider or facility. A CC with a valid Medicaid participation agreement in effect after February 1, 1993, with the Department of Social Services for the purpose of providing CC services to Title XIX-eligible recipients.

(5) Administrative Actions.

(A) Annual Cost Report.

1. Each CC shall complete a Medicaid cost report for the CC's twelve (12)-month fiscal period.

2. Each CC is required to complete and submit to the division an annual cost report, including all worksheets, attachments, schedules and requests for additional information from the division. The cost report shall be submitted on forms provided by the division for that purpose.

3. All cost reports shall be completed in accordance with the requirements of this rule and the cost report instructions. Financial reporting shall adhere to GAAP except as otherwise specifically indicated in this rule.

4. The cost report shall be submitted within three (3) calendar months after the close of the reporting period. A single extension, not to exceed thirty (30) days, may be granted upon the request of the CC and the

approval of the division. The request must be received in writing by the division prior to the ninetieth day of the three (3)-calendar month period after the close of the reporting period.

5. In a change of ownership, the cost report for the closing period must be submitted within forty-five (45) calendar days of the effective date of the change of ownership, unless the change in ownership coincides with the seller's fiscal year end, in which case the cost report must be submitted within three (3) months after the close of the reporting period. No extensions in the submitting of cost reports shall be granted when a change in ownership has occurred.

6. Cost reports shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report within the prescribed period, except as expressly extended in writing by the state agency, may result in the imposition of sanctions as described in 13 CSR 70-3.030.

7. Authenticated copies of agreements and other significant documents related to the provider's operation and provision of care to Medicaid recipients must be attached to the cost report at the time of filing unless current and accurate copies have already been filed with the division. Material, which must be submitted, includes, but is not limited to, the following:

A. Audit, review or compilation statement prepared by an independent accountant, including disclosure statements and management letter;

B. Contracts or agreements involving the purchase of facilities or equipment during the five (5) years if requested by the division, the department or its agents;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Schedule detailing all grants, gifts and income from endowments, including: amounts, restrictions and use;

F. Documentation of expenditures, by line item, made under all restricted and unrestricted grants, gifts or endowments;

G. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;

H. Leases or rental agreements, or both, related to the activities of the provider;

I. Management contracts;

J. Provider of service contracts; and

K. Working trial balance actually used to prepare cost report with line number tracing notations or similar identifications.

8. Under no circumstance will the

division accept amended cost reports for final settlement determination or adjustment after the date of the division's notification of the final settlement amount.

(B) Records.

1. Maintenance and availability of records.

A. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this rule, including reasonable requests by the division or its authorized agent for additional information.

B. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized agent at the same site at which the services were provided. Copies of documentation and records shall be submitted to the division or its authorized agent upon request.

C. Records of related organization, as defined by 42 CFR 413.17, must be available upon demand.

D. The division shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of the reports and will maintain those reports pursuant to the recordkeeping requirements of 42 CFR 413.20.

E. Each facility shall retain all financial information, data and records relating to the operation and reimbursement of the facility for a period of not less than five (5) years.

2. Adequacy of records.

A. The division may suspend reimbursement or reduce payments to the appropriate fee schedule amounts if it determines that the CC does not maintain records that provide an adequate basis to determine payments under Medicaid.

B. The suspension or reduction continues until the CC demonstrates to the division's satisfaction that it does, and will continue to, maintain adequate records.

(C) Audits.

1. Any cost report submitted may be subject to field audit by the division or its authorized agent.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the

same as the site where services were provided, the provider shall transfer the records to the same facility at which the services were provided, or the provider must reimburse the division or its authorized agent for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the division.

(D) Change in Provider Status. The next payment due the provider after the division has received the notification of the termination of participation in the Medicaid program or change of ownership may be held by the division until the cost report is filed. Upon receipt of a cost report prepared in accordance with this rule, the payments that were withheld will be released.

(6) Nonallowable Costs. Cost not reasonably related to CC services shall not be included in a provider's costs. Nonallowable cost areas include, but are not limited to, the following:

(A) Grants, gifts and income from endowments will be deducted from total operating costs;

(B) Bad debts, charity and courtesy allowances;

(C) Return on equity capital;

(D) Capital cost increases due solely to changes in ownership;

(E) Amortization on intangible assets, such as goodwill, leasehold rights, covenants, but excluding organizational costs;

(F) Attorney fees related to litigation involving state, local or federal governmental entities and attorney's fees which are not related to the provision of CC services, such as litigation related to disputes between or among owners, operators or administrators;

(G) Central office or pooled costs not attributable to the efficient and economical operation of the facility;

(H) Costs such as legal fees, accounting and administration costs, travel costs and the costs of feasibility studies which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition of merger for which any payment has been previously made under the program;

(I) Late charges and penalties;

(J) Finder's fees;

(K) Fund-raising expenses;

(L) Interest expense on intangible assets;

(M) Religious items or supplies or services of a primarily religious nature performed by priests, rabbis, ministers or other similar types of professionals. Costs associated with portions of the physical plant used primarily for religious functions are also nonallowable;

(N) Research costs;

(O) Salaries, wages or fees paid to non-working officers, employees or consultants;

(P) Value of services (imputed or actual) rendered by nonpaid workers or volunteers; and

(Q) Costs of services performed in a satellite clinic, which does not have a valid Medicaid participation agreement with the Department of Social Services for the purpose of providing CC services to Title XIX-eligible recipients.

(7) Interim Payments. Effective for services provided after February 1, 1993, CC services, unless otherwise limited by regulation, shall be reimbursed on an interim basis by Medicaid at ninety-five percent (95%) of usual and customary charges as billed by the provider for covered CC services. Interim payments shall be reduced by copayments and other third party liabilities.

(8) Reconciliation.

(A) The state agency shall perform an annual desk review of the Medicaid cost reports for each CC's fiscal year and shall make indicated adjustments of additional payment or recoupment, in order that the CC's net reimbursement shall be in amounts representing one hundred percent (100%) of reasonable costs.

(B) Notice of Program Reimbursement. The division shall send written notice to the CC of the following:

1. Underpayments. If the total reimbursement due the CC exceeds the interim payments made for the reporting period, the division makes a lump-sum payment to the CC to bring total interim payments into agreement with total reimbursement due the CC; and

2. Overpayments. If the total interim payments made to a CC for the reporting period exceed the total reimbursement due the CC for the period, the division arranges with the CC for repayment through a lump sum refund or, if that poses a hardship for the CC, through offset against subsequent interim payments or a combination of offset and refund.

(C) The annual desk review will be subject to adjustment based on the results of a field audit which may be conducted by the division or its contracted agents.

(9) Sanctions.

(A) The division may impose sanctions against a provider in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services or any other

sanction authorized by state or federal law or regulation.

(B) Overpayments due the Medicaid program from a provider shall be recovered by the division in accordance with 13 CSR 70-3.030.

(10) Appeals. In accordance with sections 208.156 and 621.055, RSMo, providers may seek hearing before the Administrative Hearing Commission of final decisions of the director, Department of Social Services or the Division of Medical Services.

(11) Payment Assurance.

(A) The state will pay each CC, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the CC according to the standards and methods set forth in the regulations implementing the CC Reimbursement Program.

(B) CC services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the coinsurance and deductible as imposed under Title XVIII.

(C) Where third-party payment is involved, Medicaid will be the payor of last resort.

(D) Regardless of changes of ownership, management, control, leasehold interests by whatever form for any CC previously certified for participation in the Medicaid program, the division will continue to make all the Title XIX payments directly to the entity with the CC's current provider number and hold the entity with the current provider number responsible for all Medicaid liabilities.

(12) Payment in Full. Participation in the Medicaid program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid recipients, the amount paid in accordance with these rules and applicable copayments.

*AUTHORITY: section 208.201, RSMo (Supp. 1987). * Emergency rule filed Jan. 15, 1993, effective, Feb. 2, 1993, expired June 1, 1993. Emergency rule filed June 11, 1993, effective June 21, 1993, expired Oct. 18, 1993. Original rule filed March 2, 1993, effective Aug. 9, 1993.*

**Original authority 1987.*

13 CSR 70-93.020 Reimbursement for Medicaid Family Health Clinic Program

PURPOSE: This rule establishes the regulatory basis for Medicaid (Title XIX) payment for family health clinic program services. This rule requires primary and prenatal clinics that were owned and operated by the Department of Social Services on June 30, 1994, to operate as an independent clinic provider on a not-for-profit status to be eligible for reimbursement under the Medicaid Family Health Clinic Program.

Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.

(1) Authority. This rule is established pursuant to the authorization granted to the Department of Social Services, Division of Medical Services to promulgate regulations.

(2) Qualification. For a clinic to qualify for participation in the Medicaid Family Health Clinic (FHC) Program, the clinic must meet all of the following criteria:

(A) The clinic must have qualified for reimbursement as a Department of Social Services owned and operated primary and prenatal care clinic on June 30, 1994;

(B) The clinic must have applied for a not-for-profit status exempt from federal income tax under the provisions 501(C) of the *Internal Revenue Code* as of June 1, 1995;

(C) Provide services to county residents with incomes below two hundred percent (200%) of the federal poverty level on a sliding fee scale basis, regardless of ability to pay for the services;

(D) Provide on-site, or have firm financial arrangements, for diagnostic laboratory and radiologic services, and pharmacy services; and

(E) Provide social services to patients to assist with meeting psychosocial, behavioral, and environmental needs, through linkages with community resources and collaborative activities regarding public health issues with the local health departments.

(3) General Principles.

(A) The Missouri Medical Assistance (Medicaid) Program shall reimburse FHC providers based on the reasonable cost of FHC-covered services related to the care of Medicaid recipients (within program limitations) less any copayment or other third party liability amounts that may be due from Medicaid recipients effective for services on and after February 2, 1994.

(B) Reasonable costs shall be determined by the Division of Medical Services based on desk review of the applicable cost reports and shall be subject to adjustment based on field audit. Reasonable costs shall not exceed the Medicare cost principles set forth in 42 CFR part 413.

(C) Reasonable costs shall be apportioned to the Medicaid program based on a ratio of covered charges for beneficiaries to total charges. Charges mean the regular rate for various services established uniformly for Medicaid recipients and other patients.

(4) Definitions.

(A) Desk review. The Division of Medical Services' review of a provider's cost report without on-site audit.

(B) Division. Unless otherwise designated, division refers to the Division of Medical Services, the division of the Department of Social Services charged with administration of Missouri's Medical Assistance (Medicaid) program.

(C) Facility fiscal year. A facility's twelve (12)-month fiscal reporting period.

(D) Generally accepted accounting principles (GAAP). Accounting conventions, rules and procedures necessary to describe accepted accounting practice at a particular time promulgated by the authoritative body establishing those principles.

(E) Provider or facility. An FHC with a valid Medicaid participation agreement in effect on or after February 2, 1994, with the Department of Social Services for the purpose of providing FHC services to Title XIX-eligible recipients.

(5) Administrative Actions.

(A) Annual Cost Report.

1. Each FHC shall complete a Medicaid cost report for the FHC's twelve (12)-month fiscal period.

2. Each FHC is required to complete and submit to the Division of Medical Services an annual cost report, including all worksheets, attachments, schedules and requests for additional information from the division. The cost report shall be submitted

on forms provided by the division for that purpose.

3. All cost reports shall be completed in accordance with the requirements of this rule and the cost report instructions. Financial reporting shall adhere to GAAP except as otherwise specifically indicated in this regulation.

4. The cost report shall be submitted within three (3) calendar months after the close of the reporting period. A single extension, not to exceed thirty (30) days, may be granted upon the request of the FHC and the approval of the Missouri Division of Medical Services. The request must be received in writing by the division prior to the ninetieth day of the three (3) calendar-month period after the close of the reporting period.

5. In a change of ownership, the cost report for the closing period must be submitted within forty-five (45) calendar days of the effective date of the change of ownership, unless the change in ownership coincides with the seller's fiscal year end, in which case the cost report must be submitted within three (3) calendar months after the close of the reporting period. No extensions in the submitting of cost reports shall be granted when a change in ownership has occurred.

6. Cost reports shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report within the prescribed period, except as expressly extended in writing by the state agency, may result in the imposition of sanctions as described in 13 CSR 70-3.030.

7. Authenticated copies of agreements and other significant documents related to the provider's operation and provision of care to Medicaid recipients must be attached to the cost report at the time of filing unless current and accurate copies have already been filed with the division. Material that must be submitted includes, but is not limited to, the following:

A. Audit, review or compilation statement prepared by an independent accountant, including disclosure statements and management letter;

B. Contracts or agreements involving the purchase of facilities or equipment during the last five (5) years if requested by the division, the department or its agents;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Schedule detailing all grants, gifts and income from endowments, including: amounts, restrictions, and use;

F. Documentation of expenditures, by line item, made under all restricted and unrestricted grants, gifts or endowments;

G. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;

H. Leases and/or rental agreements related to the activities of the provider;

I. Management contracts;

J. Provider of service contracts; and

K. Working trial balance used to prepare cost report with line number tracing notations or similar identifications.

8. Under no circumstances will the division accept amended cost reports for final settlement determination or adjustment after the date of the division's notification of the final settlement amount.

(B) Records.

1. Maintenance and availability of records.

A. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this regulation, including reasonable requests by the division or its authorized agent for additional information.

B. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized agent at the same site at which the services were provided. Copies of documentation and records shall be submitted to the division or its authorized agent upon request.

C. Records of related organizations, as defined by 42 CFR 413.17, must be available upon demand.

D. The Missouri Division of Medical Services shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of the reports and will maintain those reports pursuant to the recordkeeping requirements of 42 CFR 413.20.

E. Each facility shall retain all financial information, data and records relating to the operation and reimbursement of the facility for a period of not less than five (5) years.

2. Adequacy of records.

A. The division may suspend reimbursement or reduce payments to the appropriate fee schedule amounts if it determines that the FHC does not maintain records that provide an adequate basis to determine payments under Medicaid.

B. The suspension or reduction continues until the FHC demonstrates to the divi-

sion's satisfaction that it does, and will continue to, maintain adequate records.

(C) Audits.

1. Any cost report submitted may be subject to field audit by the division or its authorized agent.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location that is different from the site where services were provided, the provider shall transfer the records to the same facility at which the services were provided, or the provider must reimburse the division or its authorized agent for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the division.

(D) Change in Provider Status. The next payment due the provider after the division has received the notification of the termination of participation in the Medicaid program or change of ownership may be held by the division until the cost report is filed. Upon receipt of a cost report prepared in accordance with this rule, the payments that were withheld will be released.

(6) Nonallowable Costs. Cost not related to FHC services shall not be included in a provider's costs. Nonallowable cost areas include, but are not limited to, the following:

(A) Bad debts, charity and courtesy allowances;

(B) Return on equity capital;

(C) Capital cost increases due solely to changes in ownership;

(D) Amortization on intangible assets, such as goodwill, leasehold rights, covenants, but excluding organizational costs;

(E) Attorney fees related to litigation involving state, local or federal governmental entities and attorneys' fees that are not related to the provision of FHC services, such as litigation related to disputes between or among owners, operators or administrators;

(F) Central office or pooled costs not attributable to the efficient and economical operation of the facility;

(G) Costs such as legal fees, accounting and administration costs, travel costs and the costs of feasibility studies that are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or (instead of "of") merger for which any

payment has been previously made under the program;

- (H) Late charges and penalties;
- (I) Finder's fees;
- (J) Fund-raising expenses;
- (K) Interest expense on intangible assets;
- (L) Religious items or supplies or services

of a primarily religious nature performed by priests, rabbis, ministers or other similar types of professionals. Costs associated with portions of the physical plant used primarily for religious functions are also nonallowable;

- (M) Research costs;

(N) Salaries, wages or fees paid to non-working officers, employees or consultants; and

(O) Costs of services performed in a satellite clinic, which does not have a valid Medicaid participation agreement with the Department of Social Services for the purpose of providing FHC services to Title XIX-eligible recipients.

(7) Interim Payments. Effective for services provided on or after February 2, 1994, FHC services, unless otherwise limited by regulation, shall be reimbursed on an interim basis by Medicaid at ninety-five percent (95%) of usual and customary charges as billed by the provider for covered FHC services. Interim payments shall be reduced by copayments and other third party liabilities.

(8) Reconciliation.

(A) The state agency shall perform an annual desk review of the Medicaid cost reports for each FHC's fiscal year and shall make indicated adjustments of additional payment or recoupment, in order that the FHC's net reimbursement shall be in amounts representing one hundred percent (100%) of reasonable costs.

(B) Notice of program reimbursement. The division shall send written notice to the FHC.

1. Underpayments. If the total reimbursement due the FHC exceeds the interim payments made for the reporting period, the division makes a lump-sum payment to the FHC to bring total interim payments into agreement with total reimbursement due the FHC.

2. Overpayments. If the total interim payments made to the FHC for the reporting period exceed the total reimbursement due the FHC for the period, the division arranges with the FHC for repayment through a lump-sum refund, or, if that poses a hardship for the FHC, through offset against subsequent

interim payments or a combination of offset and refund.

(C) The annual desk review will be subject to adjustment based on the results of a field audit which may be conducted by the division or its contracted agents.

(9) Sanctions.

(A) The division may impose sanctions against a provider in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services or any other sanction authorized by state or federal law or regulation.

(B) Overpayments due the Medicaid program from a provider shall be recovered by the division in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services.

(10) Appeals. In accordance with sections 208.156 and 621.055, RSMo, providers may seek hearing before the Administrative Hearing Commission of final decisions of the director, Department of Social Services or the Division of Medical Services.

(11) Payment Assurance.

(A) The state will pay each FHC, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the FHC according to the standards and methods set forth in the regulations implementing the FHC Reimbursement Program.

(B) FHC services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the coinsurance and deductible as imposed under Title XVIII.

(C) Where third-party payment is involved, Medicaid will be the payor of last resort.

(D) Regardless of changes of ownership, management, control, leasehold interests by whatever form for any FHC previously certified for participation in the Medicaid program, the department will continue to make all the Title XIX payments directly to the entity with the FHC's current provider number and hold the entity with the current provider number responsible for all Medicaid liabilities.

(12) Payment in Full. Participation in the Medicaid program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid recipients, the amount paid in accordance with these regulations and applicable copayments.

*AUTHORITY: section 208.201, RSMo (1994). * Emergency rule filed Oct. 31, 1995, effective Nov. 10, 1995, expired April 28, 1996. Original rule filed June 30, 1995, effective Jan. 30, 1996.*

** Original authority 1987.*



**WORKSHEET INSTRUCTIONS
FOR
MEDICAID FAMILY HEALTH CLINIC
TITLE XIX COST REPORT**

STATISTICAL DATA

- Item 1: **CLINIC NAME AND ADDRESS.** Enter here the full name and address of the MFHC.
- Item 2: **CLINIC NUMBER.** Enter the MFHC identification number that was provided by the Division when the clinic entered the program.
- Item 3: **REPORTING PERIOD.** Enter the inclusive dates covered by this cost report.
- Item 4: **TYPE OF CONTROL.** Indicate by checking the type of ownership under which the facility is operated.
Check only one.
- Item 5: **MFHC OWNED BY.** The facility must be owned by the Missouri Department of Social Services in order to become a MFHC.
- Item 6: **RELATED ORGANIZATIONS.** List all clinics, providers of services, (hospitals, nursing facilities, home health agencies) suppliers or other entities that are owned, or related through common ownership or control, to the individual.
- Item 7: **PERFORMING PROVIDERS FURNISHING SERVICES AT MFHC.** List all performing providers furnishing services at the MFHC or under agreements and their Medicaid performing provider numbers.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC. This certification must be prepared and signed after the cost report has been completed in its entirety. The individual signing must be an officer or other authorized responsible person.

PREPARER OF REPORT. Enter the name and telephone number of the person who prepared the report in case further information or clarification of the report is required.

WORKSHEETS

WORKSHEET 1 - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

General Instructions

This worksheet provides for recording the trial balance of expense accounts from the MFHC's accounting books and records. The worksheet also provides for any necessary reclassification and adjustments to these accounts.

Not all of the listed cost centers will apply to each MFHC. For example, a MFHC might not employ radiology technicians and would not, in that case, complete line 10. The worksheet also provides blank lines for clinic costs and cost centers in addition to those listed in the form. If the worksheet does not provide sufficient space, enter aggregate amounts on Worksheet 1 under "other," where appropriate, and furnish a supporting schedule to list items included in the aggregate amounts.

Columns 1 through 3 - TRIAL BALANCES OF DIRECT EXPENSES

The expenses listed in these columns must be in accordance with the MFHC's accounting books and records.

Enter on the appropriate lines in columns 1 through 3 the total expenses incurred during the reporting period. The expenses must be detailed between compensation (column 1), and other than compensation and related costs (column 2). For example, payroll taxes, employee benefits, and workers' compensation